AMENDED IN ASSEMBLY JUNE 27, 2005

SENATE BILL No. 458

Introduced by Senator Speier

February 18, 2005

~~An act to amend Sections 14085.51, 14087.52, 14087.53, and 14087.51 of the Welfare and Institutions Code, relating to health care.~~ *An act to add and repeal Chapter 2.23 (commencing with Section 1399.830) of Division 2 of the Health and Safety Code, to amend Section 742.24 of the Insurance Code, and to amend Sections 14087.51, 14087.52, 14087.53, and 14087.54 of the Welfare and Institutions Code, relating to health care.*

LEGISLATIVE COUNSEL'S DIGEST

SB 458, as amended, Speier. Basic health care: counties.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans and makes a violation of the act a crime. Existing law also provides for the regulation of health insurers by the Insurance Commissioner.

This bill would authorize, until January 1, 2009, a pilot project in which up to 200,000 employees at any one time may be enrolled, and for which nonprofit community health centers, nonprofit primary care clinics, nonprofit federally qualified health centers, and look-alikes, may accept prepayment from an administering health care service plan or health insurer for provider services for up to one month at a time. The bill would require that, before January 1, 2009, an evaluation of the coverage provided pursuant to the pilot project be submitted to the Legislature.

Existing law authorizes creation of multiple employer welfare arrangements (MEWAs), which may provide certain benefits, *including health benefits, to the employees of 2 or more employers. Existing law requires that benefits be offered only to association members.*

This bill would also allow, with the permission of the Insurance Commissioner, until January 1, 2009, benefits to nonmembers. The bill would also provide that, until January 1, 2009, a multiple employer welfare arrangement not otherwise organized as of January 1, 2005, may be organized, upon approval of the commissioner without meeting certain organizational requirements.

Existing law provides for the Medi–Cal program, which is administered by the State Department of Health Services and pursuant to which health care services are provided to qualified low–income persons. Existing law authorizes San Mateo County, San Bernardino County, Ventura County, and other counties to establish a special commission in order to meet the problems of delivery of publicly assisted medical care in each county, and to demonstrate ways of promoting quality care and cost efficiency.

This bill would revise the scope of that authorization to expand the scope of the mission of the commissions to include meeting the problems of a lack of access to affordable health care coverage, and would authorize a county to establish a commission that may offer coverage for both publicly assisted medical care and privately financed medical care for both the residents of the county and residents of other counties if the commission's governing body determines that there exists a need for affordable coverage in other counties.

Vote: majority. Appropriation: no. Fiscal committee: ~~no~~ *yes*. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION. 1. Chapter 2.23 (commencing with Section 1399.830) is added to Division 2 of the Health and Safety Code, to read:

Chapter 2.23. The Chronically Uninsured Industries and Workers Access to Health Care Coverage Pilot Program Act of 2005

1399.830. As used in this chapter, the following terms have the following meanings:

(a) "Chronically uninsured industry" means an industry or occupation where employers have historically not offered health care coverage to their employees. For purposes of this pilot program, an employer is eligible to cover employees if the employer has not offered prepaid health care coverage to its hourly employees for at least one year at the time the employees are initially covered pursuant to this pilot program and at the time the employees are initially covered pursuant to this pilot program the employer has 5,000 employees or less in California.

(b) "Preventive health care" means a comprehensive benefit package that consists only of the following:

(1) Comprehensive health screens, to be provided initially and thereafter at an interval of every six months. The health screens may be provided at the employee's worksite with the consent of the employer.

(2) Preventive primary care, including general and family care, pediatrics, internal medicine, physical exams, gynecology, immunizations, family planning, and minor emergencies.

(3) Preventive dental care, including X-rays, cleanings, and fillings.

(4) Additional comprehensive services, including preventive mental health services if providers are available within health care network.

(c) "Nonprofit providers" means nonprofit community health centers, nonprofit primary care clinics, nonprofit federally qualified health centers, and look alikes, all of which shall have nonprofit status under Section 501(c)(3) of Title 26 of the United States Code as well as individual providers who are not part of the staff of nonprofit community health centers or clinics but who have non-profit status under Section 501(c)(3) of Title 26 of the United States Code. To the extent possible, nonprofit providers should have "cultural and linguistic competency" for the communities they serve as that term is defined in Section 2198.1 of the Business and Professions Code.

1399.831. This chapter authorizes a pilot project in which up to 200,000 employees at any one time may be enrolled, and for which nonprofit providers, as defined and through the process described below, may accept prepayment for provider services for up to one month at a time. The benefits described in subdivision (b) of Section 1399.830. shall be benefits required of providers authorized pursuant to this pilot project. Additional benefits may be offered by the providers or the administering health care service plan or health insurer. Family coverage may be offered under this chapter at the option of the employer based upon the employer's discussions with employees.

1399.832. An employer in a chronically uninsured industry may opt to arrange and pay for preventive health care coverage for employees through an administering health care service plan or health insurer involving health benefit guarantee contracts between an employer and one or more nonprofit medical providers, who will provide the covered services to the employees. An employer shall pay a monthly payment, which shall include an amount covering no more than the actual costs of the administering health care service plan or health care insurer in administering the coverage authorized under this chapter, for each employee to the administering health care service plan or health insurer, which shall pass through the employer's payment, less the amount covering the health care service plan or health insurer's cost of administration, to the providers. The administering health care service plan or health insurer shall not bear any risk for coverage provided under this chapter. An employee shall be covered beginning on the first day of the month, with payment due from the employer to the administering health care service plan or health insurer on or before mid-month and then to the provider on or before the last day of that month.

1399.833. Health care providers participating in this program shall be responsible for providing assistance to covered employees, family members, and relatives in seeking health care coverage from public sector programs for which they may be eligible, including, but not limited to, Medi-Cal, Medicare, Healthy Families, and any other state or federally funded health care programs.

1399.834. An employee, or dependent, if applicable, shall be responsible for a copayment for each health care service or appointment provided under this chapter. The amount of the copayment shall be determined through negotiations between employers, employees, and providers. At no time shall employees be responsible for paying a copayment and a share of cost of the monthly premium paid by the employer.

1399.835. Marketing of the health care product offered under this chapter shall be undertaken on a collaborative basis and shall involve the administering health care service plan or health insurer, medical service providers contracted to provide services under this chapter, and employer associations. Employer associations may assist the administering health care service plan or health insurer and providers in marketing, but questions and answers regarding benefits under the coverage shall be answered by a licensed broker agent, whether employed by the administering health care service plan or health insurer, the providers, the association, or any or all of these entities.

1399.836. Before January 1, 2009, an evaluation of the coverage provided under this chapter shall be submitted to the Legislature. The evaluation shall determine the positive and negative attributes and issues relative to providing a preventive-primary health care product. The evaluation shall include, but not be limited to, (1) utilization of the health care services accessed under this article, (2) patient satisfaction, (3) use of hospital emergency rooms by covered patients both prior and after availability of coverage under this chapter, (4) estimated savings to state and local general fund expenditures, (5) adequacy of clinic finances to bear the risk of one month of services under a contract of prepaid care, and (6) any other relevant matters. The evaluation shall be conducted by a philanthropic organization selected by the Insurance Commissioner and shall not require any expenditure of General Fund revenues. The Insurance Commissioner may appoint an advisory panel of no more than nine persons comprised of medical services providers, employers, employees, and administering health care service plans or health insurers for the purpose of identifying additional areas and aspects of this pilot program to be evaluated and developing a structure for carrying out the evaluation.

1399.837. Nonprofit community clinics, nonprofit primary care clinics, federally qualified health centers, and federally qualified health center look alikes shall be required to submit audited financial statements to the State Department of Health Services to substantiate their financial viability to offer a month-to-month prepaid health benefits package consistent with these provisions. Approval by the State Department of Health Services may be granted to the aforementioned clinics and centers if they have been a recipient of funds administered by the State Department of Health Services including such programs as Medi-Cal, rural and farm worker health, Expanded Access to Primary Care, Family PACT, and California Perinatal Services Program, and State Department of Health Services deems the approval appropriate to meet otherwise unmet health care needs that could be met through this pilot program. Disputes about the medical necessity of care shall be submitted to the Department of Managed Health Care and governed by the resolution of those disputes through the Department of Managed Health Care.

1399.838. This chapter shall remain in effect only until January 1, 2009, and as of that date is repealed, unless a later enacted statute, that is chaptered before January 1, 2009, deletes or extends that date.

SEC. 2. Section 742.24 of the Insurance Code is amended to read:

742.24. To be eligible for a certificate of compliance, a self-funded or partially self-funded multiple employer welfare arrangement shall meet all of the following requirements:

(a) Be nonprofit.

(b) Be established and maintained by a trade association, industry association, professional association, or by any other business group or association of any kind that has a constitution or bylaws specifically stating its purpose, and have been organized and maintained in good faith with at least 200 paid members and operated actively for a continuous period of five years, for purposes other than that of obtaining or providing health care coverage benefits to its members. An association is a California mutual benefit corporation comprised of a group of individuals or employers who associate based solely on participation in a specified profession or industry, accepting for membership any individual or employer meeting its membership criteria, which do not condition membership directly or indirectly on the health or claims history of any person, and which uses membership dues solely for and in consideration of the membership and membership benefits.

(c) Be organized and maintained in good faith with at least 2,000 employees and 50 paid employer members and operated actively for a continuous period of five years.

(d) Have been operating in compliance with ERISA on a self-funded or partially self-funded basis for a continuous period of five years pursuant to a trust agreement by a board of trustees that shall have complete fiscal control over the multiple employer welfare arrangement, and that shall be responsible for all operations of the multiple employer welfare arrangement. The trustees shall be selected by vote of the participating employers and shall be owners, partners, officers, directors, or employees of one or more employers participating in the multiple employer welfare arrangement. A trustee may not be an owner, officer, or employee of the insurer, administrator, or service company providing insurance or insurance-related services to the association. The trustees shall have authority to approve applications of association members for participation in the multiple employer welfare arrangement and to contract with an authorized administrator or service company to administer the day-to-day affairs of the multiple employer welfare arrangement.

(e) Benefits shall be offered only to association members *or, until January 1, 2009, with the permission of the commissioner, may be offered to employers who were nonmembers up to the time of enrollment. The total enrollment statewide in a single year of nonmember employees shall be 50,000 enrolled through all multiple employer welfare arrangements combined. Nonmember employers shall be eligible to offer benefits to employees if they have not offered benefits to their employees during the prior year. Nonmembers who are offered membership shall be employers who have not previously offered health insurance to their employees for one year prior to membership. The health benefits offered to these nonmembers new enrollees shall be in compliance with the benefits required pursuant to the Knox-Keene Health Care Service Plan Act of 1975*.

(f) Benefits may be offered only through life agents, as defined in Section 1622, licensed in the state whose names, addresses, and telephone numbers have been filed with the commissioner as licensed life agents for the multiple employer welfare arrangement.

(g) Be operated in accordance with sound actuarial principles and conform to the requirements of Section 742.31.

(h) File an application with the department for a certificate of compliance no later than November 30, 1995.

(i) The multiple employer welfare arrangement shall at all times maintain aggregate stop loss insurance providing the arrangement with coverage with an attachment point which is not greater than 125 percent of annual expected claims. The commissioner may, by regulation, define "expected claims" for purposes of this subdivision and provide for adjustments in the amount of the percentage in specified circumstances in which the arrangement specifically provides for and maintains reserves in accordance with sound actuarial principles as provided in Section 742.31.

(j) The multiple employer welfare arrangement shall establish and maintain specific stop loss insurance providing the arrangement with coverage with an attachment point which is not greater than 5 percent of annual expected claims. The commissioner may, by regulation, define "expected claims" for purposes of this subdivision and provide for adjustments in the amount of that percentage as may be necessary to carry out the purposes of this subdivision determined by sound actuarial principles as provided in Section 742.31.

(k) The multiple employer welfare arrangement shall establish and maintain appropriate loss and loss adjustment reserves determined by sound actuarial principles as provided in Section 742.31.

(*l*) The association has within its own organization adequate facilities and competent personnel to serve the multiple employer welfare arrangement, or has contracted with a licensed third-party administrator to provide those services.

(m) The association has established a procedure for handling claims for benefits in the event of the dissolution of the multiple employer welfare arrangement.

(n) On and after January 1, 2003, in addition to the requirements of this article, maintain a surplus of not less than one million dollars ($1,000,000), and that this amount be increased as follows: one million seven hundred fifty thousand dollars ($1,750,000) by January 1, 2004; two million five hundred thousand dollars ($2,500,000) by January 1, 2005; three million two hundred fifty thousand dollars ($3,250,000) by January 1, 2006; and four million dollars ($4,000,000) by January 1, 2007.

(o) Submit all proposed rate levels to the department for informational purposes no later than 45 days prior to their implementation. The proposed rates shall contain an aggregate benefit structure which has a loss ratio experience of not less than 80 percent. The loss ratio experience shall be calculated as claims paid during the contract period plus a reasonable estimate of claims liability for the contract period at the end of the current year divided by contributions paid or collected for the contract period minus unearned contributions at the end of the current year.

(p) (1) Comply with the investment requirements of Article 3 (commencing with Section 1170) of Chapter 2 of Part 2 of Division 1 and Section 1192.5, except for investments made pursuant to paragraph (2).

(2) (A) A multiple employer welfare arrangement may invest funds as provided in subparagraph (B) in an amount not to exceed 75 percent of any excess of invested assets over the sum of the following:

(i) The reserves and related actuarial items held in support of policies and contracts.

(ii) The surplus required by subdivision (n).

(B) The investments authorized by subparagraph (A) may be made only in an open-ended diversified management company, as defined in the federal Investment Company Act of 1940 (15 U.S.C. 80a-1 et seq.), that is registered with and reports to the Securities and Exchange Commission and is domiciled in the United States, and all of the assets of which are held in the United States by a bank, trust company, or other custodian chartered by the United States, or its territories or states.

(3) The commissioner may, in his or her discretion and after a hearing, require by written order the disposal of any investment made in violation of this section. The commissioner may also, after a hearing, require the disposal of any investment made pursuant to paragraph (2) if the multiple employer welfare

arrangement has failed to maintain cash or liquid assets sufficient to meet its claims and any other contractual obligations.

(q) Notwithstanding subdivisions (c) and (d), until January 1, 2009, a multiple employer welfare arrangement not otherwise organized as of January 1, 2005, may be organized, upon approval of the commissioner, after filing a plan of proposed operation to be approved by the commissioner, pursuant to regulations issued by the department, and upon submission to the commissioner of a management consulting contract between the multiple employer welfare arrangement that is being proposed to be organized and a multiple employer welfare arrangement that was organized and operating as of January 1, 2005. All other statutes applicable to multiple employer welfare arrangements shall otherwise be applicable to newly organized multiple employer welfare arrangements. The commissioner may approve no more than three multiple employer welfare arrangements pursuant to this subdivision. Membership shall be by employers who have not previously offered health insurance to their employees for one year prior to membership. The health benefits offered shall be in compliance with the Knox-Keene Health Care Service Plan Act of 1975.

~~SECTION 1.~~

SEC. 3. Section 14087.51 of the Welfare and Institutions Code is amended to read:

14087.51. (a) It is necessary that a special commission be established in San Mateo County and in any other county designated by the California Medical Assistance Commission in order to meet the problems of the delivery of publicly assisted medical care, or lack of access to affordable health plan coverage in the counties and to demonstrate ways of promoting quality care and cost efficiency for both publicly assisted medical care and privately financed medical care. The commission may offer coverage for privately financed medical care for residents of other counties if the governing body of the commission determines that the need for affordable coverage exists in other counties.

(b) The Board of Supervisors of San Mateo County and of the designated counties may, by ordinance, establish commissions to do any or all of the following:

(1) Negotiate the exclusive contracts specified in Section 14087.5 and to arrange for the provision of health care services provided pursuant to this chapter.

(2) Enter into contracts for the provision of health care services to subscribers in the Healthy Families Program.

(3) Enter into agreements under Chapter 5 (commencing with Section 6500) of Division 7 of Title 1 of the Government Code.

(c) In addition to the authority specified in subdivision (b), the Board of Supervisors of San Mateo County may, by ordinance, authorize the commission established pursuant to this section to provide health care delivery systems for any or all of the following persons:

(1) Persons who are eligible to receive medical benefits under this chapter in the county, including, but not limited to, persons who are eligible through federal waiver or a pilot project.

(2) Persons who are eligible to receive medical benefits under both Title 18 and Title 19 of the federal Social Security Act.

(3) Persons who are eligible to receive medical benefits under Title 18 of the federal Social Security Act.

(4) Persons who are eligible to receive medical benefits under publicly supported programs if the commission and participating providers acting pursuant to subcontracts with the commission agree to hold harmless the beneficiaries of the publicly supported programs if the contract between the sponsoring government agency and the commission does not ensure sufficient funding to cover program costs.

(d) If the board of supervisors elects to enact an ordinance pursuant to this section, all rights, powers, duties, privileges, and immunities vested in a county by an article shall be vested in the county commission. Any reference in this article to "county" shall mean a commission established pursuant to this section.

(e) The enabling ordinance shall specify the membership of the county commission, the qualifications for individual members, and any other matters as the board of supervisors deems necessary or convenient for the conduct of the county commission's activities. A commission so established shall be considered a public entity for purposes of Division 3.6 (commencing with Section 810) of Title 1 of the Government Code. All commissioners shall be appointed by majority vote of the board of supervisors and shall serve at the pleasure thereof.

The board of supervisors may appoint no more than two of its own members to serve on the commission.

(f) As an alternative to establishing a separate commission, the enabling ordinance may designate the board of supervisors itself as the commission authorized by this article.

~~SEC. 2.~~

SEC. 4. Section 14087.52 of the Welfare and Institutions Code is amended to read:

14087.52. (a) It is necessary that a special commission be established in San Bernardino County in order to meet the problems of the delivery of publicly assisted medical care, or lack of access to affordable health plan coverage in the county and to demonstrate ways of promoting quality care and cost efficiency for both publicly assisted medical care and privately financed medical care. The commission may offer coverage for privately financed medical care for residents of other counties if the governing body of the commission determines that the need for affordable coverage exists in other counties. Because there is no general law under which ~~such a~~ *this* commission could be formed, the adoption of a special act and the formation of a special commission is required.

(b) The Board of Supervisors of San Bernardino County may, by ordinance, establish a commission to negotiate the exclusive contract specified in Section 14087.5 and to arrange for the provision of health care services provided pursuant to this chapter, and to enter into contracts for the provision of health care services to subscribers in the Healthy Families Program. If the board of supervisors elects to enact this ordinance, all rights, powers, duties, privileges, and immunities vested in a county by this article shall be vested in the county commission. Any reference in this article to "county" shall mean the commission established pursuant to this section.

(c) It is the intent of the Legislature that if ~~such~~ a commission is ~~formed~~ *established pursuant to subdivision (b)*, the County of San Bernardino shall, with respect to its medical facilities and programs, occupy no greater or lesser status than any other health care provider in negotiating with the commission for contracts to provide health care services.

(d) The enabling ordinance shall specify the membership of the county commission, the qualifications for individual members, the manner of appointment, selection, or removal of commissioners, and how long they shall serve, and any other matters as the board of supervisors deems necessary or convenient for the conduct of the county commission's activities. The commission so established shall be considered an entity separate from the county, shall file the statement required by Section 53051 of the Government Code, and shall have, in addition to the rights, powers, duties, privileges, and immunities previously conferred, the power to acquire, possess, and dispose of real or personal property, as may be necessary for the performance of its functions, to employ personnel and contract for services required to meet its obligations, and to sue or be sued. Any obligations of the commission, statutory, contractual, or otherwise, shall be the obligations solely of the commission and shall not be the obligations of the county or of the state unless expressly provided for in a contract between the commission and the county or state.

(e) Upon creation, the commission may borrow from the county, and the county may lend the commission funds, or issue revenue anticipation notes to obtain those funds necessary to commence operations.

(f) In the event the commission may no longer function for the purposes for which *it was* established, at ~~such time as~~ *the time that* the commission's then existing obligations have been satisfied or the commission's assets have been exhausted, the board of supervisors may by ordinance terminate the commission.

(g) Prior to the termination of the commission, the board of supervisors shall notify the State Department of Health Services of its intent to terminate the commission. The department shall conduct an audit of the commission's records within 30 days of notification to determine the liabilities and assets of the commission. The department shall report its findings to the board within 10 days of completion of the audit. The board shall prepare a plan to liquidate or otherwise dispose of the assets of the commission and to pay the liabilities of the commission to the extent of the commission's assets, and present the plan to the department within 30 days upon receipt of these findings.

(h) Upon termination of the commission by the board, the County of San Bernardino shall manage any remaining assets of the commission until superseded by a department approved plan. Any liabilities of the commission shall not become obligations of the county upon either the termination of the commission or the liquidation or disposition of the commission's remaining assets.

(i) Any assets of the commission shall be disposed of pursuant to provisions contained in the contract entered into between the state and the commission pursuant to this article.

~~SEC. 3.~~

SEC. 5. Section 14087.53 of the Welfare and Institutions Code is amended to read:

14087.53. (a) It is necessary that a special commission be established in Ventura County in order to meet the problems of the delivery of publicly assisted medical care, or lack of access to affordable health plan coverage, in the county and to demonstrate ways of promoting quality care and cost efficiency for both publicly assisted medical care and privately financed medical care. The commission may offer coverage for privately financed medical care for residents of other counties if the governing body of the commission determines that the need for affordable coverage exists in other counties. Because there is no general law under which ~~such a~~ *this* commission could be formed, the adoption of a special act and the formation of a special commission is required.

(b) The Board of Supervisors of Ventura County may, by ordinance, establish a commission to negotiate the exclusive contract specified in Section 14087.5 and to arrange for the provision of health care services provided pursuant to this chapter, and to enter into contracts for the provision of health care services to subscribers in the Healthy Families Program. If the board of supervisors elects to enact this ordinance, all rights, powers, duties, privileges, and immunities vested in a county by this article shall be vested in the county commission. Any reference in this article to "county" shall mean the commission established pursuant to this section.

(c) The enabling ordinance shall specify the membership of the county commission, the qualifications for individual members, the manner of appointment, selection, or removal of commissioners, and how long they shall serve, and any other matters as the board of supervisors deems necessary or convenient for the conduct of the county commission's activities.

The commission so established shall be considered an entity separate from the county, shall file the statement required by Section 53051 of the Government Code, and shall have, in addition to the rights, powers, duties, privileges, and immunities previously conferred, the power to acquire, possess, and dispose of real or personal property, as may be necessary for the performance of its functions, to employ personnel and contract for services required to meet its obligations, and to sue or be sued. Any obligations of the commission, statutory, contractual, or otherwise, shall be the obligations solely of the commission and shall not be the obligations of the county or of the state.

(d) Upon creation, the commission may borrow from the county and the county may lend the commission funds, or issue revenue anticipation notes to obtain those funds necessary to commence operations.

(e) In the event the commission may no longer function for the purposes for which *it was* established, at ~~such time as~~ *the time that* the commission's then existing obligations have been satisfied or the commission's assets have been exhausted, the board of supervisors may by ordinance terminate the commission.

(f) Prior to the termination of the commission, the board of supervisors shall notify the State Department of Health Services of its intent to terminate the commission. The department shall conduct an audit of the commission's records within 30 days of notification to determine the liabilities and assets of the commission. The department shall report its findings to the board within 10 days of completion of the audit. The board shall prepare a plan to liquidate or otherwise dispose of the assets of the commission and to pay the liabilities of the commission to the extent of the commission's assets, and present the plan to the department within 30 days upon receipt of these findings.

(g) Any assets of the commission shall be disposed of pursuant to provisions contained in the contract entered into between the state and the commission pursuant to this article.

(h) It is the intent of the Legislature that if ~~such~~ a commission is ~~formed~~ *established pursuant to subdivision (b)*, the County of Ventura shall, with respect to its medical facilities and programs, occupy no greater or lesser status than any other health care provider in negotiating with the commission for contracts to provide health care services.

(i) Upon termination of the commission by the board, the County of Ventura shall manage any assets of the commission until superseded by a department approved plan. Any liabilities of the commission shall not become obligations of the county upon either the termination of the commission or the liquidation or disposition of the commission's remaining assets.

~~SEC. 4.~~

SEC. 6. Section 14087.54 of the Welfare and Institutions Code is amended to read:

14087.54. (a) Any county or counties, including counties subject to Section 14087.51, 14087.52, or 14087.53, may establish a special commission in order to meet the problems of the delivery of publicly assisted medical care, or lack of access to affordable health plan coverage, in the county or counties and to demonstrate ways of promoting quality care and cost efficiency for both publicly assisted medical care and privately financed medical care. A commission may offer coverage for privately financed medical care for residents of other counties if the governing body of the commission determines that the need for affordable coverage exists in other counties.

(b) A county board of supervisors may, by ordinance, establish a commission to negotiate the exclusive contract specified in Section 14087.5 and to arrange for the provision of health care services provided pursuant to this chapter. The boards of supervisors of more than one county may also establish a single commission with the authority to negotiate an exclusive contract and to arrange for the provision of services in those counties. If a board of supervisors elects to enact this ordinance, all rights, powers, duties, privileges, and immunities vested in a county by this article shall be vested in the county commission. Any reference in this article to "county" shall mean a commission established pursuant to this section.

(c) It is the intent of the Legislature that if a county forms a commission pursuant to this section, the county shall, with respect to its medical facilities and programs occupy no greater or lesser status than any other health care provider in negotiating with the commission for contracts to provide health care services.

(d) The enabling ordinance shall specify the membership of the county commission, the qualifications for individual members, the manner of appointment, selection, or removal of commissioners, and how long they shall serve, and any other matters as a board of supervisors deems necessary or convenient for the conduct of the county commission's activities. A commission so established shall be considered an entity separate from the county or counties, shall be considered a public entity for purposes of Division 3.6 (commencing with Section 810) of Title 1 of the Government Code, and shall file the statement required by Section 53051 of the Government Code. The commission shall have in addition to the rights, powers, duties, privileges, and immunities previously conferred, the power to acquire, possess, and dispose of real or personal property, as may be necessary for the performance of its functions, to employ personnel and contract for services required to meet its obligations, to sue or be sued, and to enter into agreements under Chapter 5 (commencing with Section 6500) of Division 7 of Title 1 of the Government Code. Any obligations of a commission, statutory, contractual, or otherwise, shall be the obligations solely of the commission and shall not be the obligations of the county or of the state.

(e) Upon creation, a commission may borrow from the county or counties, and the county or counties may lend the commission funds, or issue revenue anticipation notes to obtain those funds necessary to commence operations.

(f) In the event a commission may no longer function for the purposes for which it was established, at ~~such time as~~ *the time that* the commission's then existing obligations have been satisfied or the commission's assets have been exhausted, the board or boards of supervisors may by ordinance terminate the commission.

(g) Prior to the termination of a commission, the board or boards of supervisors shall notify the State Department of Health Services of its intent to terminate the commission. The department shall conduct an audit of the commission's records within 30 days of the notification to determine the liabilities and assets of the commission. The department shall report its findings to the board or boards within 10 days of completion of the audit. The board or boards shall prepare a plan to liquidate or otherwise dispose of the assets of the commission and to pay the liabilities of the commission to the extent of the commission's assets, and present the plan to the department within 30 days upon receipt of these findings.

(h) Upon termination of a commission by the board or boards, the county or counties shall manage any remaining assets of the commission until superseded by a department approved plan. Any liabilities of the commission shall not become obligations of the county or counties upon either the termination of the commission or the liquidation or disposition of the commission's remaining assets.

(i) Any assets of a commission shall be disposed of pursuant to provisions contained in the contract entered into between the state and the commission pursuant to this article.

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